Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 19, 2020	2020_593573_0016	003038-20, 016133-20	Critical Incident System

Licensee/Titulaire de permis

The Glebe Centre Incorporated
950 Bank Street OTTAWA ON K1S 5G6

Long-Term Care Home/Foyer de soins de longue durée

Glebe Centre
950 Bank Street OTTAWA ON K1S 5G6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 21 - 25, and 28, 2020

The following critical incidents were inspected during this inspection:
-Log #003038-20, related to the resident's fall with an injury.
-Log #016133-20, related to alleged staff to resident emotional abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Manager of Nursing Care Operations, Director of Quality Management, Director of Food Services, Registered Nurses (RN), Social Worker (SW), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

In addition, the inspector reviewed resident health care records and the licensee's policy and procedure RC 4.00.00 on "Resident Abuse and Neglect Prevention and internal investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was protected from emotional abuse by the Food Service Worker (FSW).

Emotional abuse is defined under O.Reg. 79/10 as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

In March, April, July and August 2020, during separate meetings with the SW, the resident reported incidents were the FSW allegedly emotionally abused the resident. The resident reported that they were upset and frustrated with the FSW’s inappropriate behaviour and attitude towards them during meal services. The SW reported the resident’s concerns and the allegations immediately to the Director of Food Services. The Director of Food Services verified with the inspector that they were notified of the concerns and allegations against the FSW, and further they indicated that they spoke to the resident and followed up with the FSW in relation to the allegations.

In August 2020, licensee’s internal investigation confirmed that staff to resident emotional abuse had occurred and disciplinary actions were taken against the FSW.

This inspection revealed that the FSW continued to provide care and services to the resident until August 2020. The FSW continuing to work on unit resulted in more than one incident of the FSW to the resident emotional abuse. As such, the licensee failed to protect the resident from emotional abuse by the FSW.

Sources: licensee’s internal investigation notes and an interview with the Director of Quality Management and other staff.

A Compliance Order CO #001 in relation to s. 19. (1) duty to protect was issued on July 08, 2020 (A1), with the compliance date on October 31, 2020 (A1), by Inspector #148 in Inspection Report # 2020_617148_0007 (A1). [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #002 was protected from emotional abuse by Food Service Worker #102, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's policy that promotes zero tolerance of abuse was complied with.

The licensee's policy and procedure RC 4.00.00 on “Resident Abuse and Neglect Prevention ” revised date :June 2020 related to investigation and reporting required that employee(s) to report any witnessed, suspected or alleged incident of resident abuse to the nurse on duty. Further, the policy directs the nurse receiving a report of alleged abuse or neglect to “notify the MOHLTC if the alleged, suspected or witnessed or un-witnessed incident of abuse or neglect of a resident meets the criteria for Ministry notification. The decision about whether to submit a report on an alleged incident of abuse or neglect will depend upon whether the circumstances of the alleged abuse or neglect meet the definitions of abuse in LTCHA Section 2(1) (Appendix A).”

Inspector conducted a separate interview with the SW, and the Director of Food Services regarding the alleged incidents of the FSW to the resident emotional abuse. The SW and the Director of Food Services indicated to the inspector that they suspected that the FSW to the resident emotional abuse had occurred. The SW stated that they reported all the allegations immediately to the Director of Food Services but not reported to the nurse on duty. The Director of Food Services acknowledged that all the allegations of the FSW to the resident emotional abuse were not reported to the nurse on duty nor the MLTC Director.

Inspector spoke with the RPN regarding the alleged incidents of the FSW to the resident emotional abuse. The RPN indicated to the inspector that they were aware of the resident’s allegations and suspected that staff to resident abuse had occurred. The RPN stated that they spoke with the Director of Food Services regarding the resident’s allegations. Further, the RPN confirmed that they did not report the incident to their supervisor, nor the MLTC Director.

As cited in the evidence above, the Director of Food Services, the SW and the RPN did not comply with the licensee’s Resident Abuse and Neglect Prevention policy/ procedure to promote zero tolerance of abuse of the residents.

Sources: licensee’s policy on “Resident Abuse and Neglect Prevention" and interview with the Director of Food Services, SW #101 and RPN #103. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee's policy that promotes zero tolerance of abuse was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of the resident by the FSW had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to the FSW to the resident alleged emotional abuse.

Inspector spoke with the Director of Quality Management, the Director of Food Services, the SW and the RPN reverified that the allegations of the FSW to the resident emotional abuse where not immediately reported to the MLTC Director.

As such, the Director of Quality Management, the Director of Food Services, the SW and the RPN who suspected that the FSW to the resident emotional abuse had or might had occurred failed to report the MLTC Director immediately as per the LTCHA section 24.

Sources: Critical Incident System report, licensee’s investigation notes, and interview with the Director of Quality Management, the Director of Food Services and the RPN. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse of resident abuse by anyone had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 22nd day of October, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.